Sunderland Partnership

A Domestic Homicide Review of the death of Derek

January 2021

EXECUTIVE SUMMARY

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Dated: 3rd May 2022

Contents

1. The Review Process

1.1 This summary outlines the process undertaken by the Safer Sunderland Partnership Domestic Homicide Review Panel in reviewing the manslaughter of Derek who was resident in their area. Derek was killed by his adult son.

1.2 'Derek' is a pseudonym, used throughout this review to protect the victim's identity. The perpetrator in this case is referred to by the pseudonym, 'Keith.'

Subjects of the Review:

The victim; Derek, a male aged 77 years at the time of his death.

The perpetrator; Keith, a male aged 42 years at the time of the incident that led to the death.

1.3 Criminal proceedings were completed in July 2021. The perpetrator appeared for trial at Newcastle Crown Court in May 2021 but pleaded guilty to manslaughter on the opening day. The plea was accepted by the prosecution. Sentencing was adjourned for reports. In July 2021 Keith appeared at Newcastle Crown Court and was sentenced to 11 years and 10 months imprisonment for the manslaughter of his father.

1.4 The review began on 27th July 2021 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 16th September 2021. This was convened remotely due to the restrictions in place at that time with the COVID-19 pandemic. All agencies that had contact with Derek or Keith were asked to secure their files and confirm their involvement. Six agencies submitted Individual Management Reviews (IMRs). The panel met again on 6th January and 3rd March 2022. The Review was concluded in May 2022.

1.5 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself."

1.6 The statutory guidance states the purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

- To establish whether the events leading up to the homicide could have been predicted or prevented.

2. Contributors to the review

2.1 The following agencies contributed to the review by provision of chronologies, Individual Management Reviews or summary reports:

- Sunderland Clinical Commissioning Group
- National Probation Service
- Northumbria Police
- North-East Ambulance Service
- Cumbria, Northumbria, Tyne & Wear NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust

The IMR authors were completely independent and had no role in any of the decisions made or actions undertaken by their respective agencies prior to Derek's death.

3. The Review Panel members

3.1 The Domestic Homicide Review panel was comprised of the following people:

- Mike Cane - Independent Chair and Author
- Wendy Proctor, Designated Nurse, Safeguarding Adults, Sunderland Clinical Commissioning Group
- Dr Chandra Anand, Named GP, Safeguarding Adults, Sunderland Clinical Commissioning Group
- Detective Chief Inspector Shelley Hudson, Safeguarding (South), Northumbria Police
- Stephen Laverton, Strategic Manager, Community Safety & Safeguarding, Sunderland City Council
- Gary Connor, Head of Probation Delivery Unit, Sunderland
- Becky Rogerson, Chief Executive, 'Wearside Women in Need' (from 2nd panel)
- Jane Stubbings, Named Safeguarding Lead, North-East Ambulance Service
- Sheona Duffy, Acting Team Manager, Named Nurse, Safeguarding and Public Protection, Cumbria, Northumbria, Tyne & Wear NHS Foundation Trust (CNTW)
- Tracy Dawson, Named Nurse, Safeguarding Adults, South Tyneside and Sunderland NHS Foundation Trust
- Ashleigh Scott, 'Change, Grow, Live' (from 2nd panel)

3.2 The panel convened on three occasions. This gave the opportunity for constructive dialogue and professional challenge. All panel members were independent of any decision-making or line management responsibilities of any staff involved in contact with the victim or perpetrator.

4. Author of the overview report

4.1 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the Safer Sunderland Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and tackling organised crime. He has extensive experience both as an author and panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

5. Terms of Reference for the review

5.1 The following terms of reference were agreed by the Review panel with regards to the death of Derek:

- Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

- Did the agency have policies and procedures in place relating to domestic abuse? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Were there any opportunities for professionals to raise safeguarding concerns in relation to the perpetrator's parents?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- What information was known about the perpetrator? How accessible were services?

- Was the perpetrator subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

  MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

  MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse.

- Were senior managers of the agencies and professionals involved at the appropriate points?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

- Did any restructuring during the period under review have any impact on the quality of service delivered? How did the onset of the COVID-19 pandemic affect service delivery?

6. Summary chronology

6.1 The victim, Derek, was 77 years old at the time of his death. For an older man, he was in relatively good health. He attended regular routine health check-ups and engaged well with his GP Practice. Derek had very little contact with any other agencies. He was not in receipt of any services under the Care Act 2014.

6.2 The perpetrator was his adult son Keith, who was 42 years old at the time of the incident. Keith had been living with his parents for several months prior to the incident. Keith had a history of violence and had abused alcohol and drugs for many years.

6.3 There was only one previous recorded incident of violence between Derek and Keith. This occurred nearly 20 years before the tragic incident in December 2020. In November 2001 police received a call from Derek stating he had been assaulted by his 23 year old son and that his son was still in the house. The notes state 'both parties had consumed quite a bit of alcohol'. Derek had suffered a split upper and lower lip. Keith was arrested. Derek gave a retraction statement and no charges were brought against Keith. Keith had also received a split lip and grazed eye during the incident.

6.4 Keith was a perpetrator of domestic abuse to three separate intimate partners. Police were called on many occasions. This resulted in court cases and Keith receiving separate restraining orders to protect his victims. His sentences included a Community Order and a Suspended Sentence Order which were managed by the Probation Service. The Community Order required Keith to engage in Rehabilitation Activity Requirements (RAR) and Building Better Relationships (BBR) programmes. He completed a BBR programme twice in relation to separate partners.

6.5 Keith was a frequent user of medical services. These included his GP, main hospital trusts and mental health services (specifically addiction services). He was not registered with any disability. His reasons for accessing the services were linked to drug and alcohol abuse which meant Keith had panic attacks, anxiety and low mood.

6.6 Police records confirm Keith's previous 19 arrests and 7 convictions for harassment, threatening behaviour, battery, assault, driving with excess alcohol and affray. In addition, Northumbria Police had recorded 17 previous domestic abuse incidents where Keith had perpetrated violence or abuse towards his father and three previous partners.

6.7 Keith's relationships were referred to the MARAC several times. This is the 'Multi-Agency Risk Assessment Conference' which convenes to exchange information and carry our safety planning in relation to the highest risk cases of domestic abuse ; those where the victim is assessed as at risk of significant harm.

6.8 On Christmas Eve 2020, Keith's sister arrived at her parent's home in Sunderland to spend Christmas with them. She had her two young children with her. The sister had no idea Keith was staying there and the visit was made on the understanding that Keith would not be present. His sister was worried about his drunkenness in front of her children. While she was unpacking her belongings from the car, the elder of her children went upstairs then came straight back down and said, "there is a man upstairs". This was her brother, Keith. She then began to collect her things and took hold of her children to get back in the car to leave. Her father, Derek, said "I'm sick of this".

Keith was on his way downstairs at this point. He knocked his father to the floor and began punching and throttling him. Keith's sister telephoned the police and Keith was arrested at the scene. His father was still conscious but was dazed. Derek initially declined to go in an ambulance. However, he subsequently did go to hospital with a suspected bleed on the brain. Sadly, he died in hospital on 18th January 2021.

7. Key issues arising from the review

7.1 The victim had very little contact with any agency, outside those caring for his medical needs.

7.2 The perpetrator was a former professional footballer. His career was ended through his own excessive use of alcohol. This led to further abuse of both alcohol and drugs.

7.3 Although there were many recorded incidents of domestic abuse between the perpetrator and several of his intimate partners, there was only one (historic) reported incident of violence between father and son. There was no suggestion of any problems within the family home (i.e. with his wider family).

7.4 There are several examples of good practice both within and between agencies aimed at managing the perpetrator's behaviour and assisting him with abstinence or reduction in his use of alcohol. However, this did not include home visits which may have given the opportunity to assess wider risks within the home.

8. Conclusions and lessons learned

8.1 This is a tragic case of an adult male killing his own father during a violent, drunken attack.

8.2 The perpetrator was known to many services as a violent man who had previously assaulted and harassed his partners as part of his domestic abuse.

8.3 Alcohol (and to a lesser degree drug abuse) was a significant part of the perpetrator's life. We know of an incident of violence in 2001 when both Derek and Keith received injuries. Both were said to be drunk at the time. Keith also disclosed that he lost a friend who died through alcohol abuse. He was not diagnosed as alcohol dependent, but alcohol was clearly a trigger for his violent behaviour to others and also for his own thoughts of self-harm. He was offered referrals to other specialist services but frequently missed appointments or did not return calls to professionals.

8.4 The service supporting him in his excessive alcohol misuse carried out an excellent comprehensive assessment of the perpetrator's needs but there was no consideration of the risks he posed to others, such as partners or wider family members sharing a home with him.

8.5 There was poor communication between agencies regarding the perpetrator's Community Order and the associated 'Building Better Relationships' (BBR) programme. There is no recorded contact between the probation practitioner and 'Wear Recovery' (CNTW's addiction service). Keith was not made subject to a statutory requirement by the Court such as an Alcohol Treatment Order. If he had been, then this would have provided the authority for information sharing. As Keith's involvement with 'Wear Recovery' was voluntary, any information sharing between the two agencies would have required Keith's written consent. However, whilst the Probation Service would not routinely notify addiction services of their involvement with an individual, it would be considered good practice for the probation practitioner to seek the consent of the person on probation to speak with caseworkers from Wear Recovery and to share relevant information for those cases in treatment.

8.6 He was referred to the MARAC in Sunderland (the Multi-Agency Risk Assessment Conference) in 2019 in relation to an assault and harassment of his ex-partner. The MARAC meets to discuss the highest risk cases (where the victim is at risk of serious harm). An action from that meeting (in November 2019) was to refer the perpetrator to the MATAC process (Multi-Agency Tasking and Coordination). The MATAC considers actions to prevent further domestic abuse by serial perpetrators. Keith was correctly identified as a serial perpetrator of domestic abuse. But the action of forwarding his case from the MARAC to the MATAC did not take place.

This was a missed opportunity to carry out a focussed intervention with Keith. He was about to start the BBR programme. But a MATAC referral would have ensured all agencies were aware of the case and potentially offer a more holistic approach. Without it, agencies were acting in isolation. It is accepted that cases must be prioritised if the highest risk offenders are to be effectively managed under the MATAC process. But once rejected by the MATAC threshold, there does not appear to have been any update provided to the MARAC Chair. As the perpetrator's nomination as a MATAC subject was the only action from the MARAC meeting, this meant a lack of ownership.

8.7 Action was not always taken when the perpetrator failed to comply with elements of his Community Order. This was a mandatory sanction after his conviction at court. It was managed by the Probation Service. Of 68 appointments offered to the perpetrator, 37 of these were kept. Nine of the absences were recorded as 'acceptable' (due to medical reasons, court or rescheduled by the probation practitioner).Two were recorded as 'unacceptable.' The other twenty absences are not recorded and appear to be technical errors on the probation system as a result of the automatic scheduling in advance of appointments, in relation to expected attendance at groups. Many of these errors were due to COVID-19, the imposition of an Exceptional Delivery Model and incorrectly showed as a 'failed' appointment. So in summary, Keith's attendance was satisfactory but there was no challenge to his two unacceptable absences.

8.8 Clear evidence of escalation and tension was given in May 2020 when the perpetrator's mother telephoned the Initial Response Service at the Cumbria, Northumberland and Tyne & Wear Mental Health Trust. She described her son as an alcoholic who had been drinking since the breakdown of his relationship and that he was going to 'kill someone'. Although there was a 'FACE' risk assessment completed by 'Wear Recovery' in June 2020, the assessed level was 'low apparent risk'. This assessment did not reflect the information from the previous month recorded by the Initial Response Service following the telephone call from his mother, though it did include a 'risk of harm to others'. However, this information was not shared with other agencies.

8.9 The victim lived at home with his wife. Their son had been staying at their home intermittently for several years. They were a source of support to him. The victim had been assaulted by his son 19 years before the attack that led to his death. There are no further records of any threats or assaults on his father. Since 2001, Derek did not disclose or even suggest to any professional that he felt at any risk of harm from his son.

8.10 The COVID-19 pandemic and the associated national 'lock-down' had a significant impact on this case. Many services had to adapt their delivery models as staff were prevented from meeting their clients face to face. Telephone contact replaced meetings in person. This affected GPs, the

CNTW services and the Probation Service. Although the perpetrator was still active to the Probation Service, these new restrictions meant that the offender had to withdraw from group work, had no personal face to face contact with his probation officer or his programme team staff member and was left to his own devices at home (when his work had been identified as a supportive factor). It also meant that if tensions were suspected, there was no chance of a home visit which could have collated more information through direct conversations with the perpetrator's parents. The unified Probation Service now has a 'Home Visit Policy Framework' in place alongside a set of National Standards for Practice. Consideration must be given in each case to a home visit. Those considered high risk must have one completed within a set timescale. If a home visit is not considered necessary, a clear rationale as to why that is the case must be recorded.

9 . Recommendations

1. Agencies should explore the feasibility of closer liaison between the Probation Service, Cumbria, Northumberland and Tyne & Wear NHS Trust, the GP Practice and other support services when a perpetrator is being managed as part of a mandatory order imposed by the courts. Even in cases where there is no Alcohol Treatment Order in place, such dialogue (subject to data protection considerations and existing Information Sharing Agreements) would be a valuable tool in managing risk.

2. The Probation Service, Mental Health Trusts and commissioned substance misuse services should review their policies regarding involvement with family members of clients, patients and offenders. A risk assessment can only be enhanced if there is a full picture of the home environment. Including other members of the household will provide better protection for the wider family.

3. Sunderland Partnership should review the processes for managing serial or repeat perpetrators of domestic abuse. The existing MATAC structures have only limited resources. These should remain in place in order to manage the highest risk cases. However, there are gaps in the level of proactivity in managing those serial domestic abuse perpetrators that fall outside the MATAC process. Multi-agency policies should be updated to incorporate a review of resources, briefings and toolkits that can be made available to those professionals managing these individuals.

4. The distribution of actions and minutes following a MARAC meeting should be reviewed. Some agencies (notably GP Practices) receive all relevant information prior to the meeting but do not receive a full account of the actions, deliberations and updated information emanating from a MARAC discussion, unless there is a specific action for that particular GP Practice. Improved information sharing of these MARAC outcomes would assist such services when considering the safety and welfare of their patients.

5. Sunderland Partnership coordinates a training event, utilising this DHR, to support the awareness of the issue of ‘adult family homicide’. There have been significant improvements in the identification of domestic abuse in recent years; particularly around such elements as physical, sexual and economic abuse and coercive control within intimate partner relationships. Some agencies remain confident that staff are also aware of the issue of wider household violence. However, more multi-agency awareness raising should take place relating to the significant violence and abuse taking place across

the wider family environment and in particular how professionals can manage these risks.

6. Sunderland Partnership (supported by the Safeguarding Adults Board and Children's Partnership) should ensure there are clear and accessible pathways for victims of wider familial abuse to seek help and support.

These recommendations will be incorporated into 'SMART' action plan with leadership and scrutiny provided by the Safer Sunderland Partnership.

Glossary

MARAC Multi-Agency Risk Assessment Conference

MATAC Multi-Agency Tasking and Coordination

CNTW Cumbria, Northumberland, Tyne & Wear NHS Trust (mental health services)

FACE Functional Analysis of Care Environments